CHESTERFIELD COUNTY
Youth Group Home
9610 Krause Road
Chesterfield, VA 23832

Telephone: (804) 748-1612

PHYSICAL EXAMINATION

Please fill out completely.

Resident's Name: _____
Last First MI

Birth Date: ____ /____/____ SS#: _____ Sex: _____

Address: _____
City State Zip

Home Phone: _____

Height: _____ Weight: _____ BP: _____ Pulse: _____
Temperature: _____

Allergies to food, medicine, insect bites/ stings or other reactions: _____
_____

Nutritional requirements including special diets if any: _____
_____

Prescription medicines taken regularly: _____
_____

Restrictions to physical activities: _____
_____

Please check all that apply.

	Equipment used by child		Chronic or Recurring Conditions
	Prosthesis (cane, crutch, limb)		Alcoholism/ Drug Abuse
	Brace		Cancer
	Hearing Aids		Epilepsy/ Seizures
	Glasses		Kidney disease
	Helmet		Sickle Cell Anemia
	Wheelchair or walker		Diabetes
	Special Shoes		Head/ spinal chord injury, CNS disease
	Other (please list):		Skin disorders
			Heart disease
			Asthma
			Hepatitis
			Sexually transmitted disease
			Other (please list):

Systems Examination	Normal	Abnormal	Comments About Findings
General appearance			
Posture, Gait			
Skin			
Head			
Vision			
Hearing:			
Right ear			
Left ear			
Nose			
Throat			
Teeth			
Neck			
Heart			
Lungs			
Abdomen			
Genitalia (Tanner Stage)			
Bone, Joints, Muscles			
Neurological			
Behavioral Observations:			
Cooperation			
Emotional tone			
Activity level			

Females Only:
Pregnancy Test Administered: _____ Pregnant: _____ Delivery Date: _____
Hospital: _____ Recommendations for follow up care: _____
_____

Immunizations administered during exam: _____
_____

PPD administered: _____ Read: _____ Result: _____
Date Date

_____Youth appears to be free from communicable disease including TB.

Recommendations for further treatment, immunizations, and other examinations: _____
_____
_____
_____

Physician's Signature: _____ Date:_____

Medical Center:_____

Address: _____ Phone: _____